The Physician Factor:
Doctor-Driven Components of LTC Costs

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LTC Doctors

What we know:

- Nursing homes must have Medical Directors
  - Director almost always attending physician for some/many of the residents
- Patients have a right to choose their personal physician (from among those with staff privileges)
  - One study in NY - Avg. of 8.6 different physicians per NH
    - Almost certainly fewer in WV

LTC Doctors

What we don't know: (Everything else!)

- How many doctors see any patients in any NH?
  - 77% of physicians surveyed spent no time in NH
    - Survey 1991; data compiled and published 1997; summarized in DHHS review in 2005
    - 2014, after the rise of hospitalist medicine, etc. - ????
- What are their qualifications?
  - Minority are geriatricians; in WV a tiny minority
  - Most *are* Primary Care physicians
    - Variable and usually *small* amounts of geriatric-specific training
    - Too many are physicians nearing retirement and "slowing down"

LTC Medical Decisions

What doctors' actions drive LTC costs?

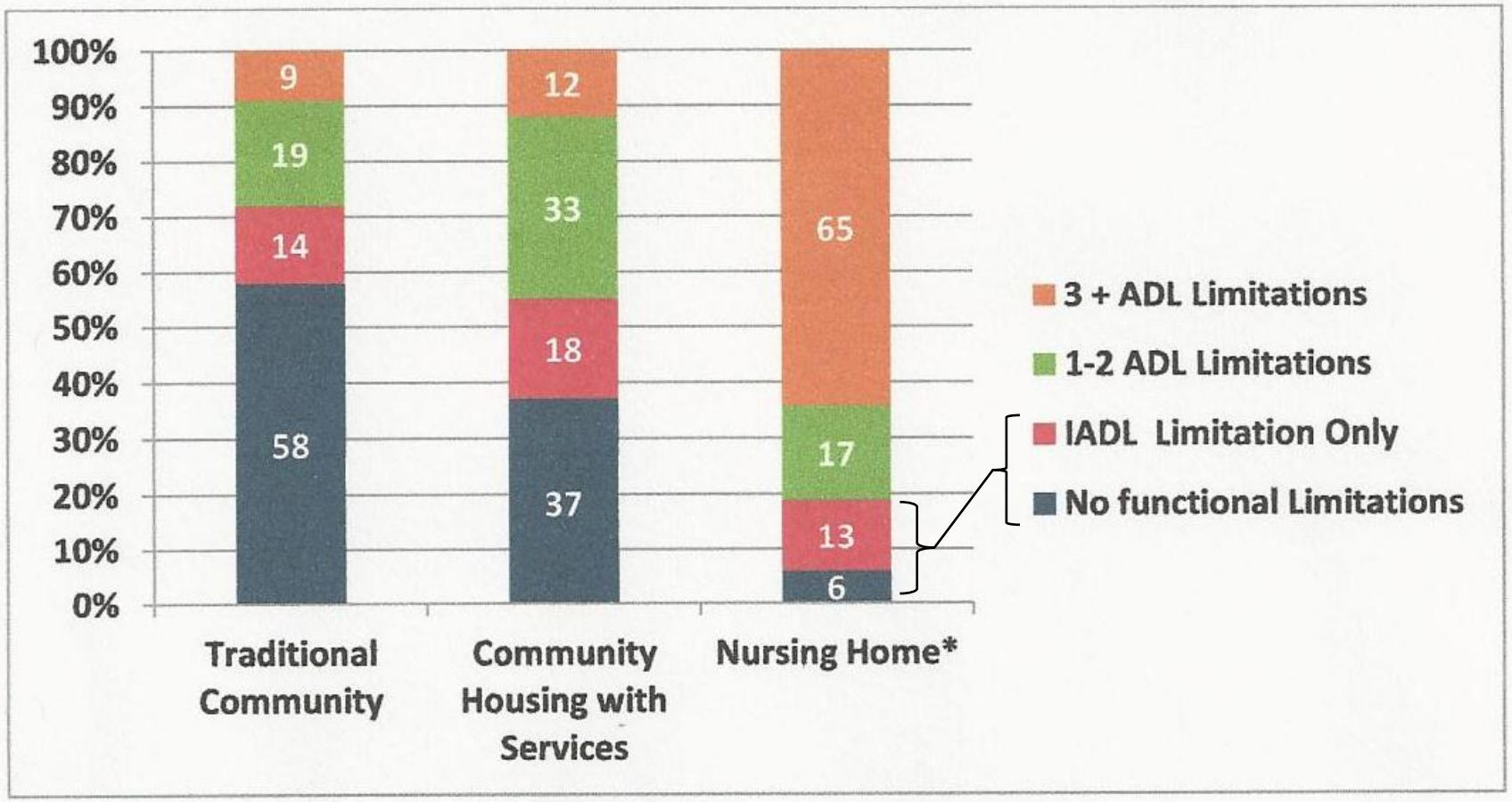
- Decisions to:
  - admit to NH
  - transfer to and from acute care
  - discharge from NH
- Decisions regarding goals of care
- Medication and therapy choices

Decisions for admission to and discharge from NH

+/- doctors' role

- Family decision with variable amount of consultation
- Sometimes pressured for hospital d/c and NH is best **or** only choice
- Doctors should assume some role in determination of appropriateness of admission

Chart 4: Percent of Medicare Enrollees Age 65 and Over with Functional Limitations by Residential Setting, 2002



Source 4: Day, T. (2012). About Long Term Care, National Care Planning Council http://www.longtermcarelink.net/eldercare/long_term_care.htm *total does not add to 100% due to rounding

Decisions for admission to and discharge from NH – Are there ways to improve?

+/- doctors' role

- Family decision with variable amount of consultation
  - "Critical conversations" have rarely taken place
    - Encourage families to do this – "high-level advance care planning"
  - Financial and social factors more important than doctors' input

- Sometimes pressured for hospital d/c and NH is quickest, best, or only choice
  - Can make medically-based decisions only

- Doctors should assume some role in determination of appropriateness of admission & d/c
  - Can be educated to assess more precisely, but *alternatives must be available*

Transferring to acute care

- Dual eligible beneficiaries in NH have ~ 1.5 million hospitalizations/yr
- Up to 39% may be avoidable
- Doctor's order required to send patient from NH to hospital

How might transfers be decreased?

Why are patients transferred?

- Change in condition that makes SOMEONE uncomfortable
  - Patient, family, staff, doctor
- Factors producing the discomfort are different for each group, except for certain situations which are universally concerning:
  - Uncontrollable bleeding
  - Uncontrollable seizures
  - Uncontrollable pain

How might transfers be decreased?

Patients' concerns:

- If alert and competent, patients' directives are followed
- Alert and competent patients need to have discussed goals of care with their doctors, which should lead to good decisions
  - Advance Directives, POST forms, etc.
    - Documentation *of discussion* and *of pt./family choices* for code/no code and transfer/no transfer should be required
- Inform, communicate, repeat!!

How might transfers be decreased?

Families' concerns:

- Goals of care and how they mesh with facility capability
- Educate and keep updated about patients' conditions

How might transfers be decreased?

Staff concerns:

- Staffing levels
  - Revisit minimums
- Their genuine concerns for patients' welfare
  - Educate about goals of care and possible treatment outcomes/futility
- Facility capabilities other than personnel – labs, X-rays, therapy, etc.
  - Not only obtaining tests but informing doctor of results
- Liability

How might transfers be decreased?

Physicians' concerns:

- Am I getting the full true story?
  - Sufficient and sufficiently competent staff
- How fast can I determine what's going on?
  - Labs, X-rays
  - Information needs – isolation, etc.
    - Accessible common source for reliable information needed!

How might transfers be decreased?

Physician concerns cont.

- How efficiently can pt. get needed tx?
  - Most common conditions leading to transfer from LTC to acute care:
    Pneumonia, Heart Failure, UTI, Dehydration, COPD exacerbation
  - So, can my patient get :
    - Medications, treatments in a timely way – pharmacy delivery, “emergency box”, etc.
    - And is there staff to administer tx?
- Am I following patient’s wishes?
  - Documentation of discussion
- What liability might I be incurring?

Physician actions driving costs

*Admit/transfer/discharge

*Discussion of goals of care

Decisions about medications

Physician actions driving costs

Improving medication decisions – less costly & still safe ?

- Education
  - When to start and when to stop
  - “Bad drugs for the elderly” ?
    - Beers List ≠ Bible !!
- Formularies
  - Streamline process to use formulary preferences
- One non-doctor driven med issue
  - Destruction of unused meds

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Summary of Suggested Actions

1. Review qualifications required to serve as medical director:
   Geriatrician care reduced transfers to ER by 133/1000 NH residents/yr
2. Review NH staffing minimums:
   If more staff reduce transfers, $$$ saved
3. Create a central source for LTC physicians and staff to get reliable recommendations for issues such as isolation procedures, etc.
4. Strengthen educational requirements for staff:
   More than 2 hours Alzheimer's training, and consider stronger requirements for DONs
5. Consider issues in liability reform
6. Review/revise medication destruction policies